UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

RHONDA A.,

Plaintiff,

v. 1:19-CV-781(TWD)

COMMISSIONER OF SOCIAL SECURITY,

Defendant.

APPEARANCES:

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THÉRÈSE WILEY DANCKS, United States Magistrate Judge

ORDER

Presently before the Court in this action, in which Plaintiff seeks judicial review of an adverse administrative determination by the Commissioner, pursuant to 42 U.S.C. §405(g), are cross-motions for judgment on the pleadings.[1] Oral argument was conducted in connection with those motions on July 24, 2020, during a telephone conference at which a court reporter was

[1] This matter, which is before me on consent of the parties pursuant to 28 U.S.C. § 636(c), has been treated in accordance with the procedures set forth in General Order No. 18. Under that General Order, once issue has been joined, an action such as this is considered procedurally as if cross-motions for judgment on the pleadings had been filed pursuant to Rule 12(c) of the Federal Rules of Civil Procedure.

present. At the close of argument I issued a bench decision in which, after applying the requisite deferential review standard, I found the Commissioner's determination resulted from the application of proper legal principles and was supported by substantial evidence, and I provided further detail regarding my reasoning and addressing the specific issues raised by the Plaintiff in her appeal.

After due deliberation, and based upon the Court's oral bench decision, which has been transcribed, is attached to this Order and is incorporated in its entirety by reference herein, it is hereby,

ORDERED, as follows:

(1) Defendant's motion for judgment on the pleadings is **GRANTED**;

(2) The Commissioner's determination that Plaintiff was not disabled at the relevant times, and thus is not entitled to benefits under the Social Security Act, is **AFFIRMED**; and

(3) The Clerk is directed to enter judgment, based upon this determination, dismissing Plaintiff's complaint in its entirety.

SO ORDERED.

Dated: July 30, 2020
Syracuse, New York

Therèse Wiley Dancks
United States Magistrate Judge

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK
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RHONDA A.,

Plaintiff,

vs. 1:19-CV-781

COMMISSIONER OF SOCIAL SECURITY,

Defendant.
----------x

Transcript of a **Decision** held during a Telephone Conference on July 24, 2020, the HONORABLE THÉRÈSE WILEY DANCKS, United States Magistrate Judge, Presiding.

A P P E A R A N C E S

(By Telephone)

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(The Court and counsel present by telephone.)

THE COURT: I have before me a request for judicial review of an adverse determination by the Acting Commissioner under 42 United States Code Section 405(g).

The background is as follows: Plaintiff was born in February of 1973 and is currently 47 years old. She was 43 years old at the onset of her alleged disability. She has a high school diploma. She has not engaged in substantial gainful activity since the alleged onset date. She previously worked jobs that included a cashier, a bakery clerk, and a baby-sitter. In her application for benefits, she indicated she suffers from neuropathy of both hands and feet, depression, asthma, and gastrointestinal problems.

Procedurally, plaintiff filed for Title II benefits on May 26, 2016, and for Title XVI benefits on June 27, 2016. Both applications alleged disability beginning specifically on May 5th of 2016. A hearing was conducted by Administrative Law Judge Kieran McCormack on May 23, 2018, wherein plaintiff testified as did a vocational expert. The plaintiff was represented by an attorney at the hearing who also represented plaintiff through the Appeals Council process. ALJ McCormack issued a decision on July 5, 2018, finding that plaintiff was not disabled at the relevant times. The Social Security Administration made that a final determination of the agency by the Appeals Council's May 5,

2019 denial of plaintiff's request for review. This timely District Court action followed.

ALJ McCormack applied the five-step sequential test for determining disability. At step one, he found plaintiff had not engaged in substantial gainful activity since the onset date of disability. At step two, he concluded plaintiff has the following severe conditions: Diabetes mellitus, diabetic neuropathy, degenerative disc disease of the cervical and lumbar spine, osteoarthritis of the right knee, bilateral carpal tunnel syndrome, morbid obesity, asthma and chronic rhinitis, and major depressive disorder. At step three, the ALJ concluded that plaintiff's conditions do not meet or medically equal any of the listed presumptively disabling conditions, considering several physical conditions related to spine and joint disorders, asthma, diabetes, peripheral neuropathy, and also the mental health listings. Then after a review of the record evidence, the ALJ determined plaintiff is capable of performing sedentary work, but with several detailed additional nonexertional limitations considering her physical and mental abilities. At step four, the ALJ concluded plaintiff could not perform any of her past relevant work. At step five, the ALJ applied the Medical-Vocational Guidelines as well as obtained testimony from a vocational expert, and concluded that plaintiff was not disabled.

As relevant to the time period in question, plaintiff treated for primary care at Hudson River Healthcare. She saw a nurse practitioner there as well as several physicians, mainly Dr. Welch-Philp, and she also saw a podiatrist there. She was also treated at Westchester Neurology mainly by Dr. Qureshi, and also by sleep specialist Dr. Malkani, and nurse practitioner Doblin. During the relevant time period, she also treated at Gastroenterology of Westchester with Dr. Fallick, and at Spinal Pain and Rehabilitation Medicine with Dr. Shah and a physical therapist. She also received gastroenterology care from Dr. Turchioe, and orthopedic care from Dr. Kalache. She was followed mainly for allergy testing and care by Dr. Nowak of ENT and Allergy Associates, and for mental health care by providers at Mental Health Associates of Westchester. The administrative record also contains treatment notes of two emergency department visits at Saint Joseph's Hospital in Yonkers, New York, and a short admission there for chest pain.

During the relevant time period, diagnostic studies performed include various x-rays of her chest, her lumbar and cervical spine, her hands, and her right hip, knee, and ankle. She had various gastroenterology scopes, an EEG in July 2016, a sleep study in November 2016, and various MRIs of the lumbar spine, brain, and cervical spine. The relevant

cervical MRIs were done June 27, 2016 and April 6, 2018. She also had nerve conduction studies performed in September and November of 2017.

Source statements in the record are from Dr. Neghassi of Hudson River Healthcare, and Dr. Elias from Mental Health Associates of Westchester. Other opinions included in the record are from internal medicine consultant Dr. Wissner, who opined on plaintiff's physical limitations, and consult -- excuse me, and psychologist consultant Dr. Antiaris who conducted a psychological evaluation. Agency reviewer psychologist Dr. Dambrocia also provided an opinion regarding plaintiff's limitations.

I've reviewed the record carefully and in light of the arguments of counsel and what counsel have presented in their briefs, I've applied the requisite deferential standard which requires me to determine whether proper legal principles were applied and whether the result is supported by substantial evidence.

I'll turn first to the plaintiff's argument that the ALJ erred in evaluating Listing 1.04 regarding plaintiff's cervical spine impairments. A claimant is automatically entitled to benefits if his or her impairment meets criteria set forth in "the Listings" found in 20 C.F.R. Part 404, subpart P, appendix 1. The burden is on the plaintiff to present medical findings that show her

impairments match a listing or are equal in severity to a listed impairment. In order to show that an impairment matches a listing, the claimant must show her impairment meets all of the specified medical criteria. If a claimant's impairment manifests only some of those criteria, no matter how severely, the impairment does not qualify. The ALJ should set forth a sufficient rationale in support of his decision to find or not to find a listed impairment. Where it is unclear what evidence the ALJ relied on in making the step three determination, the court may recommend remand. However, a court may also look to other portions of the ALJ's decision as credible evidence in finding that the ALJ's determination was supported by substantial evidence. In other words, if an ALJ's decision lacks an express rationale for finding that a claimant does not meet a Listing, a court may still uphold the ALJ's determination if it is supported by substantial evidence.

Plaintiff argues that her cervical impairments satisfy the criteria for spinal disorders in Listing 1.04, subsection A, which requires evidence of a nerve root compression, characterized by "neuro-anatomic distribution of pain; limitation of motion of the spine; and motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by sensory or reflex loss." I find the record is clear that the plaintiff has not exhibited each of the

necessary neurological deficits found in the listing and that the ALJ explained it in his decision.

The ALJ cited several MRIs to support this determination. The cervical spine MRI in June of 2016 showed no foraminal impingement and no abnormal spinal cord intensity. The lumbar MRI in 2016 showed no spinal stenosis, and no compromise of the spinal cord canal or foramina. The April 2018 MRI of the cervical spine, which plaintiff argues shows definitive nerve root compression, is unclear and ambiguous as it indicates a mild disc bulge at C6-C7 is "possibly slightly impinging the right C7 nerve root." Even if the MRI had shown clear nerve root compression, other substantial evidence in the record shows that plaintiff did not meet the neurological deficits required by the subject listing since the impairment must also involve motor loss, which is atrophy associated with muscle weakness, or muscle weakness. For example, rehabilitation and pain specialist Dr. Shah repeatedly charted from June of 2017 through February of 2018 that plaintiff's neurologic exams showed intact motor and sensory findings, and symmetrical deep tendon reflexes, although plaintiff did exhibit muscle spasms and tenderness in the cervical area. The Westchester neurologists Dr. Qureshi and Dr. Malkani also repeatedly noted that plaintiff's motor strength was intact to confrontation in upper and lower extremities. Although she

had tenderness in her cervical paraspinal area bilaterally, her muscle tone was normal. She had normal strength and normal deep tendon reflexes in both upper extremities. Dr. Wissner's consultative exam performed during the relevant time period showed full range of motion in plaintiff's cervical spine. On exam, plaintiff had no muscle atrophy in her extremities, and her strength and deep tendon reflexes were equal at 5 out of 5 in the upper and lower extremities. Plaintiff's grip strength was 5 out of 5 bilaterally. Thus, I find that substantial evidence supports the ALJ's determination that plaintiff's cervical impairment does not meet the relevant listing requirement. I also find that, although the ALJ did not outline plaintiff's medical records concerning her cervical impairments when determining whether they met the listing criteria, he specifically referenced that he discussed the medical evidence in another section of the decision. Indeed, the ALJ later detailed all of plaintiff's medical records including her cervical condition when determining her RFC. It's entirely proper to read the ALJ's decision in whole to determine whether substantial evidence supports the conclusions.

Next, I turn to plaintiff's arguments that the ALJ erred in determination of plaintiff's residual functional capacity, or RFC, and specifically that the ALJ did not give proper weight to the opinion evidence. I have done a

thorough and searching review of the record and find that the ALJ properly assessed the medical and nonmedical evidence of record and the RFC is supported by substantial evidence. The ALJ thoroughly discussed the medical evidence and the other evidence of record, formulated the RFC based upon an assessment of all medical and nonmedical evidence as a whole for the relevant time period, and thoroughly explained his analysis in arriving at the RFC.

The ALJ's decision shows he considered plaintiff's testimony, her adult function report, her activities of daily living as reported to treatment providers and consultants, and all treatment records for the relevant period. He gave significant weight to the opinion of consulting internal medicine physician Dr. Wissner. He credited the examining consulting psychologist Dr. Antiaris' opinion with significant weight to the extent it reflected her clinical observation, but gave it little weight regarding the conclusion that plaintiff's psychiatric problems would not interfere with her ability to function on a daily basis because the record showed otherwise. The ALJ also gave significant weight to nonexamining agency psychologist Dr. Dambrocia. He gave little or no more than some weight to the opinion of Dr. Neghassi who provided a diabetes source statement, and gave little weight to treating psychiatrist Dr. Elias. Of note, I reviewed the records thoroughly and

could find not one treatment note authored by Dr. Neghassi. Plaintiff argues the assessment of the opinions of Dr. Neghassi and Dr. Elias were improper because the ALJ mischaracterized the medical evidence regarding the objective findings about plaintiff's diabetes, asthma and hypertension, as well as her mental symptoms and findings and her treatment relationships with these physicians. For the following reasons, I find these arguments unpersuasive.

Initially, I note that an ALJ is not required to accept every limitation assessed by an examining consultant. There is no requirement that the ALJ accept every limitation in the opinion of a medical source or consultative examiner. Nor must the RFC identically track any one of those opinions. The ALJ has the responsibility of reviewing all of the evidence before him, resolving inconsistencies, and making a determination consistent with the evidence as a whole. In other words, it is the ALJ's responsibility to weigh the various opinions along with other evidence and determine which limitations were supported by the overall evidence of record. The court cannot re-weigh the evidence under the substantial evidence review standard. Here, I find the ALJ clearly considered all of the opinions and other evidence of record when determining plaintiff's overall RFC including the mental limitations. I have done a thorough and searching review of the record and find the ALJ properly assessed the

opinions and gave good reasons for the weight given to the opinions.

Regarding the opinion of Dr. Neghassi from Hudson River Healthcare, the ALJ acknowledged the treatment relationship with plaintiff, but noted that the record showed plaintiff's diabetes, hypertension, and asthma were mostly well controlled and stable, and not associated with any complications, although plaintiff had exhibited a mild tremor on one encounter in April of 2017. Progress notes, for example, by Dr. Philp at Hudson River Healthcare repeatedly noted that plaintiff's type 2 diabetes was without complications, although she had some elevated fingersticks at times. Her diabetes was noted as stable with medications, and she was noted to be doing well with her diabetes. Her asthma was found to be mild and intermittent. Her blood pressure was noted to be "at goal." The podiatrist at Hudson River Healthcare noted plaintiff's neurologic exams were normal including coordination, and her joint position sense and vibratory sense were intact.

Noted observations by the physicians at Westchester Neurology also do not support Dr. Neghassi's opinion that plaintiff could stand or walk for only 10 minutes at a time and lift only 10 pounds occasionally. Dr. Qureshi and Dr. Malkani repeatedly observed plaintiff to have an unremarkable gait with no ataxia, and with adequate range of

motion in her musculoskeletal system. She had some decreased sensation mainly on her right, but she had normal reflexes and normal strength in both upper extremities. Likewise, Dr. Shah consistently noted no ataxia in her gait, and normal, intact motor and sensory exams. Orthopedist Dr. Kalache found plaintiff to have arthritis in the right knee and hip, but she had full extension and flexion of the knee. Dr. Fallick noted plaintiff's overall musculoskeletal system was normal, and she had normal balance, gait, and stance. Consultant Dr. Wissner noted plaintiff had a normal gait, could walk on heels and toes without difficulty, and she had a normal stance. Dr. Wissner also charted that no muscle atrophy was present in plaintiff's extremities and she had full and equal strength in her upper and lower extremities. Thus these medical findings support the ALJ's determination that plaintiff could do sedentary work with some limitations. Additionally, I find that while Dr. Wissner's findings were from an exam in 2016, her findings were consistent with the later observations by Drs. Shah, Qureshi, and Malkani, such that Dr. Wissner's opinions were not "stale" as plaintiff argues. I also find that while diagnostic studies showed diabetic neuropathy, the ALJ noted that to be a severe condition and the decision shows he clearly considered it in limiting plaintiff to sedentary work with additional limitations. As such, I find no error with

the ALJ's consideration of Dr. Neghassi's opinion.

Turning now to the opinion of Dr. Elias of Mental Health Associates of Westchester regarding plaintiff's mental capacity, I find the ALJ properly considered it and the little weight attributed to it was also supported by substantial evidence. The ALJ noted the treatment relationship Dr. Elias had with plaintiff, and his findings on exam of the plaintiff, and the findings of other health professionals regarding plaintiff's mental status. The mental status evaluations of plaintiff done at Mental Health Associates between April of 2016 and January of 2018 repeatedly show plaintiff to be appropriately groomed, with no abnormal psychomotor behavior exhibited. Her speech always had a normal rate and rhythm. Her affect was consistently euthymic, meaning it was normal. Her mood was good and her thought process was logical. Her attention and concentration were good and she had fair judgment and insight. She denied hallucinations, delusions, and suicidal ideation, although she was noted to have attempted suicide in 2015 before the relevant date of disability. She was always noted to be oriented in all spheres also, and with average intellectual functioning. Her attitude was good and she was engaged in her treatment. In short, these findings were consistently normal and consistent with other evidence in the record and inconsistent with Dr. Elias' expressed opinion.

For example, Dr. Qureshi and Dr. Malkani noted that she was alert and responded to questions appropriately. Dr. Fallick found her to have anxiety, but no sleep disturbances and no depression. Dr. Shah repeatedly found her affect and behavior normal and appropriate. Dr. Nowak charted that she was oriented in all spheres, and had normal level of consciousness, and normal memory. The providers at Hudson River Healthcare consistently found plaintiff to be fully alert and oriented with a pleasant mood and normal eye contact. Consultant Dr. Antiaris also found plaintiff to have appropriate eye contact, with normal posture and motor behavior. Her speech was fluent and clear. Her thought processes were coherent and goal oriented. Her mood was normal, and she had a full range and appropriate affect. Her sensorium was clear and she was oriented in all spheres. Her attention and concentration were mildly impaired due to her limited intellectual functioning, and her cognitive functioning was below average, but her remote and recent memory were intact and she had fair judgment and good insight.

In short, I find that the ALJ considered the relevant factors when weighing Dr. Elias' opinion by noting the opinion was inconsistent with examinations and treatment notes from his own practice, as well as other treating providers as I've outlined. Plaintiff's daily activities of

living as she reported and as reported to her providers are also inconsistent with the limitations opined by Dr. Elias. Plaintiff cooked two to three times a week and prepared meals daily. She did laundry and dusting and washed dishes and she shopped. She was able to take care of her personal hygiene and she had children that she took care of. She was able to use a smartphone, she used public transportation and could handle money and pay her bills.

Plaintiff also takes issue with the ALJ giving significant weight to the opinion of nonexamining agency consultant Dr. Dambrocia. However, this opinion is consistent with other findings in the record as I've already detailed. Although Dr. Dambrocia did not personally examine the plaintiff, it is well settled that the opinions of state agency consultants can be given weight if supported by medical evidence and other evidence of record. The ALJ clearly stated, and the record supports, that he gave significant weight to Dr. Dambrocia's opinion because it was supported by the record evidence as I've outlined.

I also find all of the treatment briefly outlined above was thoroughly reviewed by the ALJ, as I've indicated earlier, and the records provide clear and substantial evidence to support the RFC determination such that meaningful judicial review is possible. In *Cichocki v. Astrue*, 729 F.3d 172, the Second Circuit stated that only

where the reviewing court is unable to fathom the ALJ's rationale in relation to the evidence in the record would remand be appropriate for further findings or clearer explanations of the decision. Here, I find the ALJ's analysis regarding plaintiff's functional limitations and restrictions affords an adequate basis for meaningful judicial review, applies the proper standards, and is supported by substantial evidence such that additional analysis would be unnecessary or superfluous. Hang on for one second, please. Okay, off the record.

(A discussion was held off the record.)

THE COURT: All in all, I find the ALJ properly weighed the opinions of record for the relevant period, gave good reasons for the weight given to the opinions, and the ALJ considered all of the medical evidence showing mostly limited findings on the mental exams. The ALJ also properly considered plaintiff's own reported activities per her testimony, her function report, and as she reported to providers and consultants. All of this supports the ALJ's determination of plaintiff's RFC. In short, I find the ALJ properly explained the reasons for the RFC. In light of the foregoing and considering the entire record and the ALJ's determination, I find the ALJ applied the appropriate legal standards of review in considering the opinion evidence in determining plaintiff's RFC and the RFC is supported by

substantial evidence.

So I grant defendant's motion for judgment on the pleadings and I will enter a judgment dismissing plaintiff's complaint in this action. A copy of the transcript of my decision will be attached to the order should any appeal be taken from my determination.

(Whereupon the proceedings continued.)

CERTIFICATE OF OFFICIAL REPORTER

I, JODI L. HIBBARD, RPR, CRR, CSR, Federal Official Realtime Court Reporter, in and for the United States District Court for the Northern District of New York, DO HEREBY CERTIFY that pursuant to Section 753, Title 28, United States Code, that the foregoing is a true and correct transcript of the stenographically reported proceedings held in the above-entitled matter and that the transcript page format is in conformance with the regulations of the Judicial Conference of the United States.

Dated this 28th day of July, 2020.

/S/ JODI L. HIBBARD

JODI L. HIBBARD, RPR, CRR, CSR
Official U.S. Court Reporter